Medicaid 201: Home and Community Based Services

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Purpose of Session

- Provide an overview of the authorities available through the Medicaid program that States may use to provide home and community-based services and supports

Medicaid Authorities That Include HCBS

- Medicaid State Plan Services – 1905(a)
- Medicaid Home and Community Based Services Waivers (HCBS) – 1915(c)
- Medicaid State Plan HCBS – 1915(i)
- Medicaid Self-Directed Personal Assistance Services State Plan Option - 1915(j)
- Medicaid Community First Choice Option – 1915(k)
- Medicaid Managed Care Authorities
- Medicaid Section 1115 demonstration waivers

Medicaid in Brief

- States determine their own unique programs
- Each State develops and operates a State plan outlining the nature and scope of services; the State Plan and any amendments must be approved by CMS
- Medicaid mandates some services, States elect to provide other services (“optional services”)
- States choose eligibility groups, optional services, payment levels, providers

Medicaid State Plan Requirements

- States must follow the rules in the Act, the Code of Federal Regulations (generally 42 CFR), the State Medicaid Manual, and policies issued by CMS
- States must specify the services to be covered and the "amount, duration, and scope" of each covered service
- States may not place limits on services or deny/reduce coverage due to a particular illness or condition
- Services must be *medically necessary*

Medicaid State Plan Requirements (cont'd.)

- Third party liability rules require Medicaid to be the "payor of last resort"
- Generally, services must be available statewide
- Beneficiaries have free choice of providers
- State establishes provider qualifications
- State enrolls all willing and qualified providers and establishes payment for services (4.19-B pages)
- Reimbursement methodologies must include methods/procedures to assure payments are consistent with economy, efficiency, and quality of care principles

Medicaid Benefits in the Regular State Plan

- **MANDATORY**
  - Inpatient hospital services
  - Outpatient hospital services
  - EPSDT: Early and Periodic Screening, Diagnostic, and Treatment services
  - Nursing Facility services
  - Home Health services
  - Physician services
  - Rural Health Clinic services
  - Federally Qualified Health Center services
  - Laboratory and X-ray services
  - Family Planning services
  - Nurse Midwife services
  - Certified Pediatric and Family Nurse Practitioner services
  - Freestanding Birth Center services (when licensed or otherwise recognized by the state)
  - Transportation to medical care
  - Tobacco Cessation counseling for pregnant women

- **OPTIONAL**
  - Prescription Drugs
  - Clinic services
  - Therapies – PT/OT/Speech/Audiology
  - Respiratory care services
  - Podiatry services
  - Optometry services
  - Dental Services & Dentures
  - Prosthetics
  - Eyeglasses
  - Other Licensed Practitioner services
  - Private Duty Nursing services
  - Personal Care Services
  - Hospice
  - Case Management & Targeted Case Management
  - TB related services
  - State Plan HCBS - 1915(i)
  - Community First Choice Option - 1915(k)

State Plan HCBS

- Some HCBS are available through the State plan:
  - Home Health (nursing, medical supplies & equipment, appliances for home use, optional PT/OT/Speech/Audiology)
  - Personal Care (including self-directed)
  - Rehabilitative Services
  - 1915(g) Targeted Case Management
  - 1915(i) State plan HCBS
  - 1915(k) Community First Choice

Medicaid Waivers

- Title XIX permits the Secretary of Health & Human Services - through CMS - to waive certain provisions required through the regular State plan process
- For 1915(c) HCBS waivers, the provisions that can be waived are related to:
  - Comparability (amount, duration, & scope)
  - Statewideness
  - Income and resource requirements

1915(c) HCBS Waivers

- 1915(c) HCBS waiver services complement and/or supplement the services that are available through:
  - The Medicaid State plan;
  - Other Federal, state and local public programs; and
  - Supports from families and communities.

1915(c) HCBS Waivers

- Is the major tool for meeting rising demand for long-term services and supports
- Permits States to provide HCBS to people who would otherwise require the level of care of Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or Hospital
- Serves diverse target groups
- Services can be provided on a less than statewide basis
- Allows for participant-direction of services

Basic 1915(c) Waiver Facts

- There are approximately 315 1915(c) waivers in operation across the country, which serve more than a million individuals.
- 1915(c) waivers are the primary vehicle used by States to offer non-institutional services to individuals with significant disabilities.
- HCBS is designed as an alternative to institutional care, supports community living & integration and can be a powerful tool in a State's effort to increase community services.

Section 1915(c) HCBS Waivers: Permissible Services

- Home Health Aide
- Personal Care
- Case management
- Adult Day Health
- Habilitation
- Homemaker
- Respite Care
- For chronic mental illness:
  - Day Treatment/Partial Hospitalization
  - Psychosocial Rehabilitation
  - Clinic Services
- Other Services

1915(c) HCBS Waiver Requirements

- **Costs:** HCBS must be "cost neutral" as compared to institutional services, on average for the individuals enrolled in the waiver.
- **Eligibility & Level of Care:** Individuals must be Medicaid eligible, meet an institutional level of care, and be in the target population(s) chosen & defined by the state.
- **Assessment & Plan of Care:** Services must be provided in accordance with an individualized assessment and person-centered service plan.
- **Choice:** Not waived under 1915(c) - HCBS participants must have choice of all willing and qualified providers.

1915(c) HCBS Waiver Requirements

- **Home and Community-Based Settings Requirements:** To ensure full access to benefits of community living and the opportunity to receive services in the most integrated setting

- **Quality:** Every waiver must include a quality improvement strategy (more on next slide)

HCBS Waiver Quality

- States must demonstrate compliance with waiver statutory assurances
- States must have an approved Quality Improvement Strategy: an evidence-based, continuous quality improvement process
- 1915(c) Federal Assurances
  - Level of Care
  - Service Plans
  - Qualified Providers
  - Health and Welfare
  - Administrative Authority
  - Financial Accountability

1915(c) HCBS Waiver Processing

- CMS approves a new waiver for a period of 3 years. States can request a period of 5 years if the waiver will include persons who are dually eligible for Medicaid & Medicare.
- States may request amendments at any time.
- States may request that waivers be renewed; CMS considers whether the State has met statutory/regulatory assurances in determining whether to renew.
- Renewals are granted for a period of 5 years.

HCBS Waiver Application and Instructions

- Waiver applications are web-based: *Version 3.5 HCBS Waiver Application*
- The application has a robust set of accompanying instructions: *Instructions, Technical Guide, and Review Criteria*
- Available at:

  https://wms-mmdl.cdsvdc.com/WMS/faces/portal.jsp

1915(i) State Plan HCBS

- Section 1915(i) established by Deficit Reduction Act of 2005; became effective January 1, 2007 and modified under the Affordable Care Act effective October 1, 2010
- State option to amend the State Plan to offer HCBS as a state plan benefit
- Unique type of State Plan benefit with similarities to HCBS waivers
- Breaks the "eligibility link" between HCBS and institutional level of care required under 1915(c) HCBS waivers; and no cost neutrality requirement

1915(i) State plan HCBS

- Modified under the Affordable Care Act, effective October 1, 2010:
  - Added state option to add a new Medicaid categorical eligibility group to provide full Medicaid benefits to individuals with incomes up to 150% of the FPL, and/or with incomes up to 300% of SSI FBR and who are eligible for a waiver
  - Added state option to disregard comparability (target populations) for a 5 year period with option to renew with CMS approval, and states can have more than one 1915(i) benefit
  - Expanded the scope of HCBS states can offer
  - Removed option for states to limit the number of participants and disregard statewideness

1915(i) Services

- States have the option to cover any services permissible under 1915(c) waivers:
  - Case management
  - Homemaker
  - Home Health Aide
  - Personal Care
  - Adult Day Health
  - Habilitation
  - Respite Care
  - **For Chronic Mental Illness**:
    - Day treatment or Partial Hospitalization
    - Psychosocial Rehab
    - Clinic Services
  - Other services necessary to live in the community

Who May Receive State Plan HCBS?

- Eligible for medical assistance under the State plan
- Reside in the community
- Have income that does not exceed 150% of FPL
- States also have the option to add a new Medicaid categorical eligibility group to provide full Medicaid benefits to individuals with incomes up to 150% of the FPL, and/or with incomes up to 300% of SSI FBR and who are eligible for a HCBS waiver
- State option to target populations (disregard Medicaid comparability requirements) for a 5 year period with option to renew with CMS approval
- Individuals must meet state-defined **needs-based criteria**

1915(i) Needs-Based Criteria

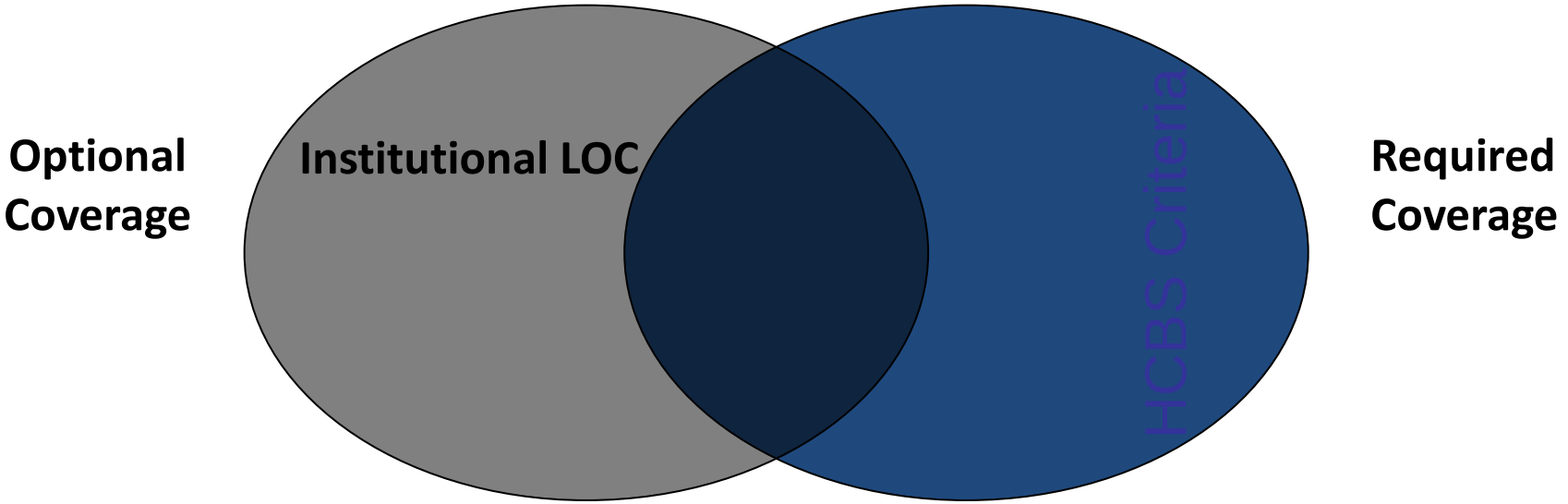
- Determined by an individualized evaluation of need (e.g. individuals with the same condition may differ in ADL needs)
- May be functional criteria such as ADLs
- May include State-defined risk factors
- Needs-based criteria are not:
  - descriptive characteristics of the person, or diagnosis
  - population characteristics
  - institutional levels of care

1915(i) Needs-Based Criteria

- The lower threshold of needs-based eligibility criteria must be “less stringent” than institutional and HCBS waiver LOC.
- But there is no implied upper threshold of need. Therefore the universe of individuals served:
  - Must include some individuals with less need than institutional LOC
  - May include individuals at institutional LOC, (but not in an institution)

1915(i) Needs-Based Criteria

- Eligibility criteria for HCBS benefit may be narrow or broad
- HCBS eligibility criteria may overlap all, part, or none, of the institutional LOC:



1915(i) State plan HCBS: Requirements

- Independent Evaluation to determine program eligibility
- Individual Assessment of need for services
- Individualized Person-Centered Service Plan
- Projection (not limit) of number of individuals who will receive State plan HCBS
- Payment methodology for each service
- Quality Improvement Strategy: States must ensure that HCBS meets Federal and State guidelines
- Home and Community-Based Settings Requirements
- Choice: Not waived under 1915(i) – Individuals must have choice of all willing and qualified providers.

Self-Direction under 1915(i)

- State option to include services that are planned and purchased under the direction and control of the individual (or representative)
- May apply to some or all 1915(i) services
- May offer budget and/or employer authority
- Specific requirements for the service plan: must include the self-directed HCBS, employment and/or budget authority methods, risk management techniques, financial management supports, process for facilitating voluntary and involuntary transition from self-direction

States with 1915(i) State Plan HCBS

- Iowa
- Colorado
- Nevada
- Oregon
- Idaho (2)
- Connecticut
- Montana
- California
- Indiana (3)
- Mississippi
- Maryland
- Delaware
- District of Columbia
- Texas
- Ohio

1915(j) Self-Directed Personal Assistance Services State Plan Option

- Provides a self-directed service delivery model for:
  - State Plan personal care benefit and/or
  - Home and community-based services under section 1915(c) waiver
- State flexibility:
  - Can limit the number of individuals who will self-direct
  - Can limit the option to certain areas of the State or offer it statewide
  - Can target the population using section 1915(c) waiver services

Section 1915(j) Features

- Individuals have “employer” authority - can hire, fire, supervise and manage workers capable of providing the assigned tasks
- Individuals have “budget” authority - can purchase personal assistance and related services from their budget allocation
- Participation is voluntary - can disenroll at any time
- Participants set their own provider qualifications and train their providers of PAS

Section 1915(j) Features

- Participants determine amount paid for a service, support or item
- Self-directed State Plan PAS is not available to individuals who reside in a home or property that is owned, operated or controlled by a provider of services not related to the individual by blood or marriage.

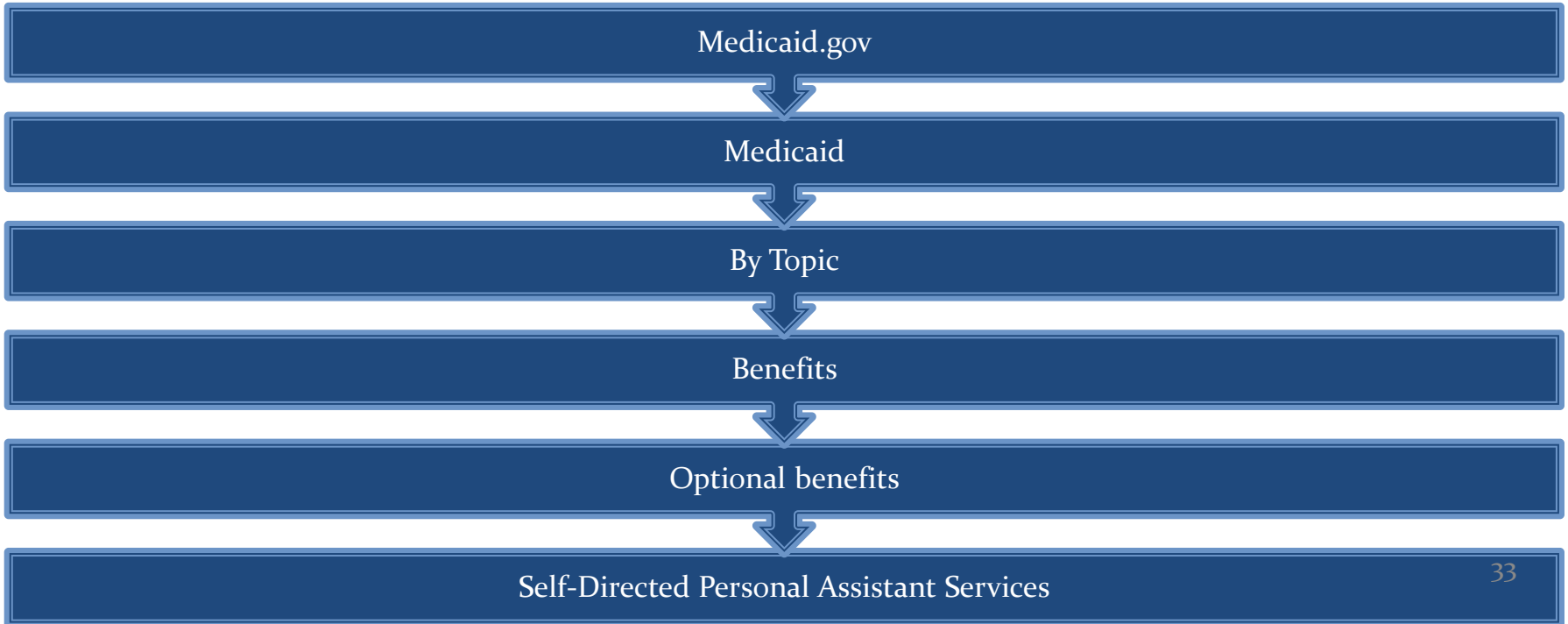
Section 1915(j)

- If the State Medicaid agency allows the following, participants can:
  - Hire legally liable relatives (e.g., parents, spouses)
  - Manage a cash disbursement
  - Allow for Permissible Purchases:
    - Purchase goods, supports, services or supplies that increase their independence or substitute for human assistance (to the extent expenditures would otherwise be made for the human assistance)
  - Use a discretionary amount of their budgets to purchase items not otherwise delineated in the budget or reserved for permissible purchases
  - Use a representative to help them direct their PAS

Section 1915(j) - Resources

- SMD Letters and Preprint

  http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/self-directed-personal-assistant-services-1915-j.html



1915(k) Community First Choice (CFC): Key Features

- State option to provide "person-centered" home and community-based attendant services and supports
- States receive 6 percentage point increase in FMAP
- Must be provided on a Statewide basis and cannot be targeted to particular populations

Who is Eligible to Receive CFC services?

- Must be eligible for medical assistance under the State plan
- Must meet an institutional level of care
- Must be part of an eligibility group that is entitled to receive nursing facility services; if not, income may not exceed 150% of FPL

CFC Services - Required

- Attendant services and supports to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing.
- Back-up systems (such as electronic devices) or mechanisms to ensure continuity of services and supports.
- The State must offer a voluntary training to individuals on how to select, manage and dismiss attendants.

Services – State's Option

- Allow for transition costs such as security deposits for an apartment or utilities, purchasing bedding, basic kitchen supplies, and other necessities required for transition from an institution.
- Allow for the provision of services that increase independence or substitute for human assistance **to the extent that expenditures would have been made for the human assistance**

Excluded Services

- Room and board
- Special education and related services provided under IDEA and vocational rehab
- Assistive technology devices and assistive technology services (other than those defined in 441.520(a)(3))*
- Medical supplies and equipment *
- Home modifications*

* These services may be provided if they meet the requirements at 441.520(b)(2)

Consumer -Directed Service Delivery Models

- Agency-provider model
- Self-directed model with a service budget
- Other service delivery model approved by the Secretary

Agency Provider Model

- Agency either provides or arranges for services
- Individual has a significant role in selection and dismissal of employees, for the delivery of their care, and the services and supports identified in the person-centered service plan.
- State establishes provider qualifications

Self-directed Model with Service Budget

- Provides individuals with the maximum level of consumer control.
- Affords the person the authority to:
  - Recruit and hire or select attendant care providers
  - Dismiss providers
  - Supervise providers including assigning duties, managing schedules, training, evaluation, determining wages and authorizing payment
- Must include Financial Management Activities
  - Must make available for those who want it, and must provide this if individuals cannot manage the cash option without assistance
- At the state's discretion, may disburse cash or use vouchers.

Service Planning Process

Assessment of Functional Need

Person Centered Planning Process

Person-Centered Plan

State Requirements

- Maintenance of Existing Expenditures
  - For the first full 12 month period in which the State Plan amendment is implemented, the State must maintain or exceed the level of State expenditures for home and community-based attendant services and supports provided to elderly or disabled individuals under the State Plan, waivers or demonstrations.
- Collaborate with a Development and Implementation Council
  - Must includes a majority of members with disabilities, elderly individuals, and their representatives.
- Establish and maintain a comprehensive continuous quality assurance system

Annual Data Collection

- Number of individuals who are estimated to receive CFC during fiscal year
- Number of individuals that received CFC during preceding year
- Number of individuals served by type of disability, age, gender, education level, and employment status
- Individuals previously served under other HCBS program under State Plan or waiver

Community First Choice: Resources

- Medicaid.gov
  - http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/community-first-choice-1915-k.html
- Final Regulation published May 7, 2012
- Final HCBS Setting Criteria published January 16, 2014

States with Approved CFC Programs

California

Oregon

Maryland

Montana

Texas

Washington

Connecticut

New York

Final Rule CMS 2249-F

- CMS published Final Regulations on January 16, 2014, that became effective on March 17, 2014 and included:
  - New regulations for 1915(i) State plan HCBS
  - New home and community-based setting requirements for 1915(c), 1915(i) and 1915(k) Medicaid authorities, to ensure full access to benefits of community living and the opportunity to receive services in the most integrated setting
  - Changes to current regulations for 1915(c) waivers, including option to combine multiple target groups in one waiver, person-centered planning, public notice, and additional compliance options for CMS

HCBS Setting Requirements

- Existing 1915(c) HCBS Waiver and 1915(i) State Plan HCBS have until March 2019 to transition their HCBS systems

- New 1915(c), 1915(i) and 1915(k) programs must be compliant prior to approval

HCBS Final Rule

- More information about the final regulation is available at:

  http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

Medicaid HCBS Provided in a Managed Care Delivery System

- HCBS are usually provided as “fee for service” – service is delivered, a claim is filed, and payment made.
- HCBS can also be provided as part of a managed care delivery system using a concurrent Medicaid managed care authority, such as a 1915(b) waiver.
- HCBS delivered with a managed care authority allow States to design and implement programs with a continuum of design features – from a limitation of providers to a fully capitated managed care arrangement that allows for risk sharing between the State and managed care entities.

Medicaid HCBS Provided in a Managed Care Delivery System

- In order to operate HCBS with a concurrent managed care authority, a state must complete and submit a separate application for each authority.
- Each application has different requirements, as each waiver authority is governed by distinct provisions of the Social Security Act and is subject to different Federal regulations.
- CMS reviews each application for its independent compliance with the various statutory and regulatory requirements.

CMS Contact Information

- For more information on 1915(c):
  - Regional Office Representative or
  - Kathy Poisal, 410-786-5940, Kathryn.Poisal@cms.hhs.gov or
  - Marge Sciulli 410-786-0691, Margherita.Sciulli@cms.hhs.gov
- For more information on 1915(i):
  - Regional Office Representative or
  - Kathy Poisal - 410-786-5940; Kathryn.Poisal@cms.hhs.gov
- For more information on 1915(j) and/or 1915(k):
  - Regional Office Representative or
  - Kenya Cantwell- 410-786-1025; Kenya.Cantwell@cms.hhs.gov